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No. 99-

IN THE

# Supreme Court of the United States

COUNTY OF LOS ANGELES, a political subdivision of the State of California, owner and operator of Los Angeles County/USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital, *et al.*,

*Petitioners,*

*v.*

DONNA E. SHALALA, Secretary, U.S. Department of Health and Human Services,

*Respondent.*

**ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT**

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTIONS PRESENTED

This case involves certain Medicare payments to hospitals, called "outlier" payments, which are provided as supplemental payments for inpatient services provided to the sickest and costliest patients. The precise questions presented to the Court are as follows:

1. Whether 42 U.S.C. § 1395ww(d)(5)(A)(iv) unambiguously requires that the actual amount of outlier payments paid nationwide during a fiscal year not be less than 5% of the total Medicare Prospective Payment System payments for inpatient services projected or estimated to be made for that year?

2. Whether, pursuant to *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), a court should afford deference to an agency interpretation of a federal statute which is not contained in an agency regulation or adjudication?

## PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

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County of Los Angeles, a political subdivision of the State of California, owner and operator of Los Angeles County/USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King, Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital, along with the other plaintiff hospitals in the consolidated cases (collectively, "Hospitals" or "Petitioners"), respectfully petition for a writ of certiorari to review that part of the Judgment of the United States Court of Appeals for the District of Columbia Circuit which was in favor of Respondent Donna E. Shalala, Secretary of the United States Department of Health and Human Services ("Secretary").

## OPINIONS BELOW

The Opinion of the United States Court of Appeals for the District of Columbia Circuit (App. A) is reported at 192 F.3d 1005 (D.C. Cir. 1999). The denial of rehearing and rehearing *en banc* (App. D) is unreported. The Judgment of the United States District Court for the District of Columbia (App. B) is reported at 992 F. Supp. 26 (D.D.C. 1998). The subsequent Order of the District Court (App. C), dated April 30, 1998, is unreported.

## STATEMENT OF JURISDICTION

The Court of Appeals entered its Judgment on October 1, 1999. (App. A). A Petition for Rehearing and Suggestion for Rehearing *En Banc* (App. D) was denied on November 30, 1999. Congress granted the Court jurisdiction over such final judgments by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

## STATUTES INVOLVED

The following federal statutes are involved in this case: 42 U.S.C. § 1395ww(d)(3)(B) and 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv). A copy of these statutes is attached at App. E. The most critical part of the statutes at issue in this case is § 1395ww(d)(5)(A)(iv), which reads as follows:

> The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

## STATEMENT OF THE CASE

These consolidated cases involve a challenge by 181 hospitals (the "Hospitals") to a determination by the Secretary of the United States Department of Health and Human Services (the "Secretary") concerning the amount of Medicare reimbursement due to the Hospitals for services during federal fiscal years ("FYs") 1985 and 1986. The amounts in dispute are for services provided to "outlier" patients, i.e., patients whose length of stay or cost of care are unusually high and for whom additional payments are made under Medicare's Prospective Payment System ("PPS"). The Hospitals seek additional outlier payments for FYs 1985 and 1986, because the amount of outlier payments for each year is less than the minimum amount mandated by the applicable federal statute, 42 U.S.C. § 1395ww(d)(5)(A)(iv).

Under PPS, for hospital fiscal years beginning on or after October 1, 1983, Medicare payments to hospitals for inpatient services are based on a fixed, predetermined rate for each hospital discharge. 42 U.S.C. § 1395ww(d)(1). The amount paid under PPS for a particular patient depends on the Diagnosis-Related Group ("DRG") to which the patient is assigned. 42 U.S.C. §§ 1395ww(d)(2)(G), (d)(3)(D). The Secretary established approximately 470 DRGs and assigned different weights to each DRG reflecting the relative resources required to treat patients within that DRG. *See generally Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 142 (D.C. Cir. 1986).

Congress recognized that certain cases ("outliers") may require unusually lengthy or costly hospital stays, significantly in excess of the norm for the DRG to which the patient is assigned. Given the fixed payment rates under PPS, a hospital treating many outlier cases could suffer substantial losses, notwithstanding the hospital's efforts to reduce costs.[1] To mitigate such losses, Congress required the Secretary to provide additional payments for outliers.[2]

The outlier mechanism is set forth in four clauses of the Medicare Act. 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) (the "outlier statute"). Clauses (i) and (ii) establish two classes

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1. Hospitals repeatedly expressed these concerns in testimony before Congress prior to the enactment of PPS. *See, e.g., Prospective Reimbursement for Hospitals: Hearings Before the Subcomm. on Health and Env't of the House of Representatives Comm. on Energy and Commerce*, 97th Cong., 97-183, 133-34, 147, 150-153 (1982).

2. The Secretary originally proposed a minimal discretionary approach to this issue, but Congress established a mandate which provided for significantly greater outlier protection.

of outlier patients, day outliers and cost outliers. Clause (iii) provides that the additional payments under clauses (i) and (ii) would approximate the marginal cost of care beyond the applicable outlier threshold.

The fourth clause of the outlier statute is at the center of this dispute. In the fourth clause, Congress required that outlier payments be within a specified range:

> The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. § 1395ww(d)(5)(A)(iv) ("section (d)(5)(A)(iv)"). The central issue in this case is whether section (d)(5)(A)(iv) establishes an absolute mandate that the 5% level be met each federal fiscal year and thereby requires that the Secretary make additional payments to make up the difference if outlier payments fall below the 5% level. The Secretary's regulations implementing the outlier statute do not address what would happen if the 5% minimum was not met in a particular fiscal year. In the preamble to the FY 1984 PPS Final Rule, the Secretary briefly explained that she was not obligated to make hospitals whole for any shortfalls which might occur, even though these amounts had been deducted from the standardized payments.[3] This policy has never been included in regulations.

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3. Outlier payments are funded from a percentage deduction to non-outlier PPS payments. 42 U.S.C. § 1395ww(d)(3)(B). If the 5% outlier payment minimum is not met for a federal fiscal year, the Medicare program realizes a windfall because it does not pay out the full amount of the pool funded by these deductions.

For FY 1985, the Secretary decided that outlier payments would be set to the minimum of 5% of the federal portion of the PPS payments,[4] and she based the outlier thresholds on 1981 (pre-PPS) data. *County of Los Angeles v. Shalala*, 192 F.3d 1005, 1009-10 (D.C. Cir. 1999). For FY 1986, the Secretary again decided that outlier payments should equal 5% of the federal portion. However, thresholds were based on 1984 data, eventually resulting in significantly reduced day outlier thresholds (and correspondingly higher amounts of outlier payments). This increase in outlier payments did not occur immediately, because the Secretary delayed implementation of the new thresholds until May 1, 1986, based on her interpretation of congressional enactments requiring that Medicare payment rates in effect on September 30, 1985 be frozen until May 1, 1986.

As it turned out, the actual amount of outlier payments made to hospitals was well below the 5% minimum for both FY 1985 and FY 1986. Actual outlier payments were only 3% of total PPS federal payments for FY 1985 and 4.4% of total PPS federal payments for FY 1986.[5] As a result,

4. Congress established a four year transition period under which PPS was gradually phased in. During this period, a portion of each hospital's payments was based on its costs incurred during a base year, referred to as the hospital-specific portion, and a portion was based on the fixed DRG payments, known as the "federal rate" or "federal portion." During the transition period, the hospital-specific portion decreased each year, while the federal portion increased each year. *See* 42 U.S.C. § 1395ww(d)(1)(C); *Washington Hosp. Ctr.*, 795 F.2d at 142 n.3. This case concerns only the federal portion of the PPS rate.

5. The Secretary did not actually publish data on outlier payment shortfalls for FYs 1985 and 1986 until 1992. *See* 57 Fed. (Cont'd)

hospitals nationwide were underpaid by approximately $241 million for FY 1985 and $101 million for FY 1986.

Hospitals dissatisfied with the final determination of their Medicare reimbursement may obtain hearings before the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo. The Hospitals herein filed timely appeals with the PRRB seeking additional outlier payments for FY 1985 and/or FY 1986. The PRRB accepted jurisdiction over each appeal and then granted the Hospitals' requests for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1), expressing no view on the merits. These cases were consolidated before the District Court.

The District Court resolved this matter on cross-motions for summary judgment. Before the District Court, the Hospitals made two principal claims. First, the Hospitals asserted that section (d)(5)(A)(iv) *required* that the total of aggregate nationwide outlier payments for a particular fiscal year must constitute between 5% and 6% of total DRG projected payments. The Hospitals argued that this statute unambiguously sets a minimum of 5% for outlier payments for each fiscal year. Second, the Hospitals claimed that the Secretary had acted in an arbitrary and capricious manner when setting outlier thresholds for FYs 1985 and 1986, because she based the outlier thresholds on outdated data.

On January 20, 1998, the District Court granted in part and denied in part the Hospitals' Motion for Summary

(Cont'd)
Reg. 23,618, 23,644 (June 4, 1992). During the course of this litigation, it was determined that the figures published in the June 1992 Federal Register were not accurate. The parties have agreed on the above-cited percentages as the best estimates available to determine the outlier shortfalls.

Judgment. The court granted the Hospitals' statutory claim, concluding that section (d)(5)(A)(iv) was not ambiguous and was susceptible to only one meaning. The court found that the statute requires the Secretary to adjust outlier payments retroactively if actual outlier payments do not reach the 5% minimum. Second, the District Court rejected the Hospitals' claim that the Secretary acted in an arbitrary and capricious manner when setting the outlier thresholds for FYs 1985 and 1986.

Upon review, the Court of Appeals reversed both of the District Court's holdings. The court reversed the judgment in favor of the Hospitals on the statutory issue, finding, unlike the District Court, that the statute in question was ambiguous. Having found ambiguity in the statute, the court, pursuant to *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), deferred to the Secretary's construction of the statute. The court also reversed the District Court's judgment in favor of the Secretary on the outlier threshold issue. The court held that the Secretary had not adequately explained her decision to ignore early PPS data when setting the outlier thresholds for FY 1985 (and the first seven months of FY 1986) and remanded the case to the Secretary "to allow her either to recalculate the outlier thresholds for fiscal years 1985-1986 or to offer a reasonable explanation for refusing to use the 1984 data in setting outlier thresholds during those years." *County of Los Angeles*, 192 F.3d at 1023.[6]

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6. *Accord Alvarado Community Hosp. v. Shalala*, 155 F.3d 1115 (9th Cir. 1998), *op. amended*, 166 F.3d 950 (1999), in which the Court of Appeals for the Ninth Circuit held that the Secretary had acted in an arbitrary and capricious manner when setting the outlier thresholds for FYs 1985 and 1986 and, further, ordered the (Cont'd)

## REASONS FOR GRANTING THE WRIT

### I. THE IMPORTANCE OF THE ISSUE.

Not only do these consolidated cases themselves involve 181 hospitals and at least $11 million in Medicare reimbursement, exclusive of interest, for hospitals treating the most severely ill patients, but also there is in excess of one billion dollars at stake for hospitals around the country concerning outlier payment shortfalls. In addition to the cases before the Court, an additional 8 cases pertaining to 1985 and 1986 and involving 50 hospitals are stayed at the District Court, with at least $5 million, exclusive of interest, at issue. Further, the resolution of the Secretary's statutory obligation to ensure that outlier payments reach the minimum 5% level will have a significant impact on many subsequent fiscal years. Data published in the Federal Register indicates that outlier payments were below the statutory minimum for FYs 1991 through 1996.[7] Based on this data, underpayments

(Cont'd)
Secretary to reset the thresholds using available early PPS data and to recalculate the outlier payments for the plaintiff hospitals based on the new thresholds. Having decided the case on this issue, the Ninth Circuit did not reach the statutory issue. Since the D.C. Circuit's decision on the outlier threshold issue was in favor of the Hospitals (although not going as far as the Ninth Circuit did in terms of remedy), the Hospitals do not seek Supreme Court review regarding this issue.

7. *See* 57 Fed. Reg. 39,746, 39,783-84 (Sept. 1, 1992); 58 Fed. Reg. 46,270, 46,347 (Sept. 1, 1993); 59 Fed. Reg. 45,330, 45,408 (Sept. 1, 1994); 60 Fed. Reg. 45,778, 45,855 (Sept. 1, 1995); 61 Fed. Reg. 46,166, 46,229 (Aug. 30, 1996); 62 Fed. Reg. 45,966, 46,041 (Aug. 29, 1997). According to the most recent figures published by the Secretary for each fiscal year, the percentages paid
(Cont'd)

nationwide for FYs 1991-1996 appear to be in excess of $3 billion. The Hospitals are aware of pending administrative appeals concerning outlier payments for FYs 1991-1996 involving approximately 1200 hospitals and more than $1 billion at issue. Numerous additional appeals are probably also pending. With so much at stake, this case has, in fact, a much more far-reaching impact than other Medicare cases accepted for review by this Court in recent years. *See, e.g., Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87 (1995); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402 (1993).

In addition to its impact on pending appeals, this Court's determination of this significant issue of statutory interpretation will have an impact on the entitlement to Medicare outlier payments of approximately 4,000 hospitals nationwide for the present and future. The adequacy of outlier payments is important to support the financial viability of hospitals treating substantial numbers of extremely ill patients and to ensure that the care for such patients is not compromised as a result of fiscal concerns. While there do not appear to have been outlier shortfalls during the period from 1997 through 1999, the language of section (d)(5)(A)(iv) remains unchanged. Judging from past experience, there is a likelihood that outlier payments will fall below the 5% level in the future, paving the way for more administrative appeals and litigation until this matter is resolved. While a denial of the petition for certiorari by this Court will leave the decision of the D.C. Circuit standing, any hospital has the option of filing a Medicare appeal in the judicial district in which it is located. Thus, if the Court does not resolve this issue now, the issue will continue to be litigated in District and Circuit Courts around the country.

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(Cont'd)
in each year were: 1991 - 4.24%; 1992 - 3.6%; 1993 - 4.2%; 1994 - 3.5%; 1995 - 3.8%; 1996 - 4.2%.

In addition to the vast impact this case has on thousands of hospitals nationwide, the issues raised in the two questions presented are of significant importance beyond the specific Medicare policy involved. First, this case focuses on judicial analysis under the first prong of the analytical framework established in *Chevron* for reviewing agency interpretations of statutes. Petitioners believe that the D.C. Circuit improperly focused on identifying a statutory ambiguity which would require the issue to be decided under step two of the *Chevron* analysis, rather than making a concerted effort to determine the statute's meaning. The question whether this approach was appropriate is extremely important, as it implicates the "duty of the judicial department to say what the law is" and raises fundamental separation of powers concerns. *See Marbury v. Madison*, 1 Cranch. 137, 177 (1803).

The second issue, whether courts should give *Chevron* deference to an agency's informal interpretation of a statute, is not only the subject of direct conflict among Circuit Courts, but is also one of substantial importance. Courts are frequently called upon to review agency interpretations which are not embodied in a regulation or adjudication. The question of what level of deference should be given to such interpretations has badly divided courts around the country and is an issue engendering increasing confusion. *See* Kenneth Culp Davis & Richard J. Pierce, Jr., *Administrative Law Treatise* § 3.5 (3rd ed. Supp. 1999). Previous pronouncements by this Court have not definitely resolved this issue, which is central to administrative law decision-making. This case presents an excellent opportunity for the Court to provide much-needed guidance.

## II. THE CIRCUIT COURT MISREAD THE OUTLIER STATUTE, WHICH UNAMBIGUOUSLY REQUIRES THAT ACTUAL OUTLIER PAYMENTS BE NOT LESS THAN 5% OF PROJECTED OR ESTIMATED DRG PAYMENTS.

The interpretation of section (d)(5)(A)(iv) should be resolved under step one of the *Chevron* framework. Under step one, the court determines "whether Congress has directly spoken to the precise question at issue," applying the traditional tools of statutory construction. *Chevron*, 467 U.S. at 843 n.9. Congressional intent concerning the minimum level of outlier payments to be made can readily be ascertained from the plain language of section (d)(5)(A)(iv):

> The *total amount of the additional payments* made under this subparagraph for discharges in a fiscal year *may not be less* than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. § 1395ww(d)(5)(A)(iv) (emphasis added). The District Court correctly recognized the lack of ambiguity in this statutory language.

The Circuit Court chose to ignore the clear statutory language and to search throughout other statutory provisions to find ambiguity where there is none. Citing this Court's recent decision in *Regions Hosp. v. Shalala*, 522 U.S. 448 (1998), in which the Court found that the phrase "recognized as reasonable" could refer to action already taken or to action about to be taken, the D.C. Circuit found that the word "made" (in the phrase "additional payments made") could

be read as either past or future tense. However, any perceived ambiguity in the tense of the word "made" is irrelevant to the question at hand: whether *actual* outlier payments, rather than *projected* payments, must be measured against the statutory minimum. Even interpreting "made" as meaning "to be made," the statutory language does not contain any ambiguity as to whether projected, rather than actual, outlier payments should be measured against the 5% minimum.[8]

More critical than the meaning of the word "made" is the fact that the modifier "projected or estimated" does not appear in the first part of section (d)(5)(A)(iv). Congress could easily have instructed the Secretary to use projections when referring to outlier payments at the beginning of section (d)(5)(A)(iv), simply by inserting the word "projected" in the first part of the clause. Because Congress used the phrase "projected or estimated" to modify total DRG payments, but did not use the phrase "projected or estimated" to modify total outlier payments, section (d)(5)(A)(iv) *must be* interpreted to require that actual outlier payments be compared with projected or estimated DRG payments. *See Russello v. U.S.*, 464 U.S. 16, 23 (1983); *Brown v. Gardner*, 513 U.S. 115, 120 (1994).[9] The Hospitals' interpretation of

8. In fact, "made" at the beginning of section (d)(5)(A)(iv) can be read to place no temporal gloss at all on the payments, i.e., the phrase "additional payments made under this subparagraph" seems intended simply to describe outlier payments. Thus, section (d)(5)(A)(iv) can be rewritten to provide that the "total amount of outlier payments for discharges in a fiscal year may not be less than 5 percent. . . ."

9. The only other textual support cited by the Circuit Court for its conclusion that section (d)(5)(A)(iv) is ambiguous is another provision of the Medicare Act, 42 U.S.C. § 1395ww(d)(3)(B), (Cont'd)

section (d)(5)(A)(iv) is further supported by a recent Senate Finance Committee Report published after the Circuit Court issued its decision. On October 26, 1999, the Senate Finance Committee issued its report in connection with the *Medicare, Medicaid, and S-Chip Adjustment Act of 1999*, S. 1788, 106th Cong. (1999), which includes revisions to the Medicare Act. One such revision would require the Secretary to implement an outlier payment mechanism for hospital outpatient services, much like the outlier mechanism established for inpatient services. In the context of explaining this provision, the Finance Committee commented on the shortfalls which have occurred for inpatient outliers:

> With regard to the inpatient PPS outlier policy, the Committee directs HCFA to comply with Section 1886(d)(5)(A) of the Social Security Act

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(Cont'd)
which, in requiring the Secretary to reduce standard PPS payments to fund outlier payments, calls for advance estimates of outlier payments to determine how large the reduction should be. *County of Los Angeles*, 192 F.3d at 1015. Turning logic and principles of statutory construction on their heads, the panel suggested that because Congress had already used the term "estimated" in § 1395ww(d)(3)(B), it probably believed it was not necessary to repeat the concept numerous paragraphs later in section (d)(5)(A)(iv). A much more reasonable conclusion would be that the explicit reference to an estimate in § 1395ww(d)(3)(B) demonstrates that Congress knew how to clearly require estimates when it intended to do so. Moreover, the use of estimates in § 1395ww(d)(3)(B) is for a different purpose. It is entirely reasonable for Congress to require the Secretary to establish an outlier pool through deductions from standard PPS payments fixed at the beginning of the year, while requiring that actual outlier payments at the conclusion of the year be between 5% and 6% of total projected PPS payments, so as to ensure that the entire outlier pool has been expended.

> for all prior fiscal years with respect to cost reports which have been appealed or are subject to reopening. Section 1886(d)(5)(A) requires the Secretary to pay hospitals under Medicare an additional amount for their costlier, sicklier patients and directs that actual outlier payments are to be between 5 and 6 percent of total projected DRG payments for each fiscal year. HCFA paid outliers less than the statutorily mandated 5% minimum for eight fiscal years and paid outliers at more than the 6% maximum for two years, with the underpayments totaling substantially more than the overpayments. The Committee is concerned that HCFA has failed to implement Congress' intent that not less than 5 percent but not more than 6 percent of total DRG payments in fact be paid as outlier payments.

S. Rep. No. 106-199, at 15-16 (1999). While the Circuit Court was advised of this recent confirmation of congressional intent in the petition for rehearing, it was not before the Circuit Court when the decision herein was originally rendered.

## III. THERE IS A CONFLICT AMONG THE CIRCUITS REGARDING WHETHER DEFERENCE SHOULD BE GIVEN TO AN ADMINISTRATIVE AGENCY'S STATUTORY INTERPRETATION NOT FOUND IN A REGULATION OR ADJUDICATION.

After concluding that section (d)(5)(A)(iv) is ambiguous, the D.C. Circuit proceeded, under the second step of the *Chevron* analysis, to give full deference to the Secretary's

policy regarding outlier payments. The Secretary's policy, under which adjustments are never made when outlier payments fall below the 5% statutory minimum, was neither developed through adjudication nor set forth in a regulation, where it would have been subject to the full notice and comment process. The policy, without cogent explanation, has only been mentioned in various preambulatory comments in the Federal Register. Because this policy was not subject to the full APA notice and comment process, it is analogous to agency policy set forth in sub-regulations or informal instructions, i.e., interpretive rules. As discussed further below, Petitioners believe that the Circuit Court would not have reached the same result if the *Chevron* level of deference had not been given to the Secretary's interpretation.

The question as to whether *Chevron* deference should be given to agency interpretations which are not found in a regulation or adjudication is one of great conflict among the circuits (and within some circuits as well). *Chevron* itself applied to legislative rules promulgated by the Environmental Protection Agency, and it established the standard whereby, if a statute is ambiguous, a court must accept an agency's regulatory interpretation of the statute as long as it is reasonable.[10] *Chevron*, 467 U.S. at 844. This left open the question as to how a court should treat an agency's interpretive rules in similar situations, i.e., when the statute being interpreted is ambiguous.

Many courts have looked for guidance to prior Supreme Court authority to determine how much weight to give to interpretive rules. In *Skidmore v. Swift*, 323 U.S. 134 (1944),

10. *Chevron* deference clearly applies to policies adopted through agency adjudications, as well as legislative rules. *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 96-97 (1995).

the Court set a standard for the weight a court should give to such rules:

> We consider that the rulings, interpretations and opinions of the Administrator under this Act, while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.

323 U.S. at 140. *See also Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977). The extent to which the *Skidmore* standard lives on after *Chevron* as an independent, less deferential standard for judicial consideration of interpretive rules is unclear.

This Court's approach has not always been consistent. In *Equal Employment Opportunity Comm'n v. Arabian American Oil Co.*, 499 U.S. 244 (1991) ("*ARAMCO*"), the Court evaluated interpretive guidelines issued by the EEOC, which had no authority to issue legislative rules or regulations. The Court followed a pre-*Chevron* case, *General Elec. Co. v. Gilbert*, 429 U.S. 125 (1976), which had used the analytical framework established by *Skidmore* when considering EEOC guidelines. The majority in *ARAMCO* does not even mention *Chevron*. In a more recent case, however, the Court has cited *Chevron* as a basis for giving "some deference" to an internal agency guideline ("akin to

an 'interpretive rule'") issued by the Bureau of Prisons and did not cite *Skidmore* or use its analytical framework. *Reno v. Koray*, 515 U.S. 50, 61 (1995).

This Court's inconsistent use of these analytical frameworks when analyzing interpretive rules has led to disarray in the manner in which the Circuit Courts have determined how much weight to give agency interpretations of statutes found in interpretive rules. As one commentator has put it, "[c]ourts are badly divided with respect to whether *Chevron* deference is due statutory interpretations announced in interpretative rules . . . . The Court should address this question definitively in order to end the rampant confusion and disagreement apparent in the circuit court opinions." K. Davis & R. Pierce, *supra*, § 3.5.

The D.C. Circuit has, in recent years, solidified its position that full *Chevron* deference should be given to interpretive rules. In *Association of Bituminous Contractors, Inc. v. Apfel*, 156 F.3d 1246, 1251-52 (D.C. Cir. 1998), the court stated, "[b]ut an agency need not promulgate a legislative rule setting forth its interpretation of a statutory term for that interpretation to be entitled to deference. . . ." The Court then deferred to the Social Security Administration's interpretation of the Coal Act, which had been explained for the first time in litigation, but which, though never expressed in a regulation, purportedly could be inferred from the agency's previous actions. Similarly, the D.C. Circuit deferred to a non-regulatory interpretation of the Medicare Act by the Secretary in *United Seniors Ass'n v. Shalala*, 182 F.3d 965, 971 (D.C. Cir. 1999), stating that such deference could be given "[e]ven if the legal briefs contained the first expression of the agency's views . . . ." *See also Tax Analysts v. I.R.S.*, 117 F.3d 607, 613 (D.C. Cir.

1997).[11] This is the same line of reasoning that the D.C. Circuit used when analyzing the policy at issue in the case before the Court, finding the Hospitals' argument "untenable" and that the Secretary's interpretation of the outlier statute was not entitled to deference because it was not adopted through either formal rulemaking or adjudication. *County of Los Angeles*, 192 F.3d at 1016.

Other circuits have followed the analytical framework adopted by the D.C. Circuit, applying *Chevron* deference to interpretive rules. The Fourth Circuit gave *Chevron* deference to the U.S. Department of Agriculture's interpretation of a statute, even though this interpretation had not been formally enacted in the form of regulations. *Warren v. N.C. Dept. of Human Resources*, 65 F.3d 385, 391 (4th Cir. 1995). The Eleventh Circuit applied *Chevron* deference to policies stated in pre-litigation opinion letters issued by the Secretary of Labor, stating clearly that, in that circuit, such policy statements are owed considerable deference. *Herman v. Nationsbank Trust Co.*, 126 F.3d 1354, 1363 (11th Cir. 1997).

On the other hand, several circuits refuse to accord full *Chevron* deference to informal agency interpretations. In *Commonwealth of Mass. v. Federal Deposit Ins. Corp.*, 102 F.3d 615 (1st Cir. 1996), the First Circuit held that the FDIC interpretation of the statutory meaning of "depositor," announced in a presentation by a staff attorney, does not warrant *Chevron* deference. "Less formal interpretations —

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11. In all these cases, the D.C. Circuit cited to *Auer v. Robbins*, 519 U.S. 452 (1997). In that case, however, this Court stated that it would defer to an agency interpretation even if that interpretation was first contained in a legal brief *only* in the context of evaluating an agency's interpretation of its own regulations, not of a Congressional enactment. *Id.* at 462-463.

policy statements, guidelines, staff instructions, and litigating positions — are not accorded full *Chevron* deference." *Id.* at 621. In *Atchison, Topeka & Santa Fe Ry. Co. v. Pena*, 44 F.3d 437 (7th Cir. 1994), the Seventh Circuit refused to give *Chevron* deference to the interpretive rules put forth by the Federal Railroad Administration, holding that the weight to be given to such rules would depend on the "'thoroughness, validity and consistency of the agency's reasoning.'" *Id.* at 442 (quoting *Orrego v. 833 West Buena Joint Venture*, 943 F.2d 730, 736 (7th Cir. 1991)). The Tenth Circuit has stated that "[m]ost circuits agree with our conclusion that *Chevron* 'deference is owed only to legislative rules and agency adjudications." *Southern Ute Tribe v. Amoco Prod. Co.*, 119 F.3d 816, 832 (10th Cir. 1997). In *Southern Ute*, the court refused to give *Chevron* deference to an opinion issued by the Solicitor of the Department of the Interior. *Id.*

Other circuits have issued inconsistent rulings on the topic, seemingly creating intra-circuit splits of authority. The Third Circuit applied *Chevron* deference to a policy stated in a letter from the HCFA Administrator to State Medicaid Directors in *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170 (3d Cir. 1995). The court stated that "[*Chevron*] deference is appropriate here even though the Secretary's interpretation is not contained in a 'legislative rule.'" *Id.* at 182, *citing Reno*, 515 U.S. at 60-61.[12] More recent opinions issued by the Third Circuit have applied what seems to be a *Skidmore* analysis, in which informal interpretations will be given deference as long as they are consistent with other agency pronouncements and further the

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12. In *Knoll*, Judge Nygaard wrote a strong, lengthy dissent, in which he argued that *Skidmore*, rather than *Chevron*, should govern the courts' analysis of interpretive rules. 61 F.3d at 190-94.

purpose of the statute. *See Cleary v. Waldman*, 167 F.3d 801, 808 (3rd Cir. 1999); *United States v. Occidental Chem. Corp.*, 200 F.3d 143, 151-52 (3rd Cir. 1999). Similarly, the Sixth Circuit has issued conflicting opinions. It has held that interpretive rules are subject to deference when they are not contrary to statute. *Your Home Visiting Nurse Servs., Inc. v. Secretary of Health & Human Servs.*, 132 F.3d 1135, 1139 (6th Cir. 1997), *aff'd*, 525 U.S. 449 (1999). On the other hand, the Sixth Circuit has withheld absolute deference to "policy statements and interpretive rulings," stating that considerable weight may only be given to such interpretations where various factors are present, including contemporaneous construction and long use. *Kelley v. E.I. DuPont De Nemours & Co.*, 17 F.3d 836, 841 (6th Cir. 1994).

The above-cited cases are a small sample of the Circuit Court opinions which have discussed this issue of administrative law when ruling on the validity of a federal agency policy. This variety of Circuit Court opinion on this important issue will lead to differing results depending on which circuit is faced with analyzing particular agency action. If the proper interpretation of the outlier statute had been decided in a circuit which applies the *Skidmore* analysis to interpretive rules, rather than giving *Chevron* deference as did the D.C. Circuit, the result of this case would have been different. The Secretary's policy refusing to assure that outlier payments met the statutory 5% minimum was announced in a preamble to the final 1984 PPS regulations, but the analysis was neither thorough nor valid. The Secretary did little more than cite to the "projected or estimated" language in section (d)(5)(A)(iv) and state that the Medicare program would not adjust DRG payments to compensate hospitals for funds that were not actually paid for outlier cases. 49 Fed. Reg. 234, 265-66 (Jan. 3, 1984). As explained

above, the "projected or estimated" language in the statute did not apply to outlier payments, but rather to total DRG payments, but the Secretary offered no analysis or explanation of why her informally-stated policy was diverging from the statutory language. While the absolute deference given under *Chevron* led the D.C. Circuit to accept the Secretary's outlier policy, the more rigorous scrutiny required under *Skidmore* would have led the court to reject the policy due to the cursory nature of the reasoning behind it.

The Hospitals believe that the better-reasoned cases apply the *Skidmore* factors to the analysis of interpretive rules. The Court should take this opportunity to clarify the extent to which *Chevron* has or has not modified the reach of *Skidmore*, so that all courts will address the review of federal agency policies under a common standard.

## CONCLUSION

For the foregoing reasons, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the D.C. Circuit.

Respectfully submitted,

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